SERFF Tracking Number:	*FLHI-126686878*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Co.*	*State Tracking Number:*	*46052*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*AR PPO Schedule of Benefits and TMJ Lifetime Maximum Rider*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Coventry Health and Life Insurance Co.

Product Name: AR PPO Schedule of Benefits and TMJ Lifetime Maximum Rider	SERFF Tr Num: FLHI-126686878	State: Arkansas
TOI: H16G Group Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 46052
Sub-TOI: H16G.001A Any Size Group - PPO	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Nora Ambros, Tony Jones	Disposition Date: 08/06/2010
	Date Submitted: 06/25/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 08/06/2010	Explanation for Other Group Market Type:
	State Status Changed: 08/06/2010
Deemer Date:	Created By: Tony Jones
Submitted By: Tony Jones	Corresponding Filing Tracking Number:
PPACA: Not PPACA-Related	

Filing Description:

We are filing a PPO Schedule of Benefits for small and large groups along with a TMJ Maximum Lifetime Benefit Rider. Rates are not affected by these forms.

If you have any questions, please let me know.

Respectfully,

SERFF Tracking Number:	*FLHI-126686878*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Co.*	*State Tracking Number:*	*46052*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*AR PPO Schedule of Benefits and TMJ Lifetime Maximum Rider*		
Project Name/Number:	*/*		

Tony Jones
800-445-1425 x 7610

Company and Contact

Filing Contact Information

Tony Jones, Regulatory Compliance Analyst	tdjones1@cvty.com
3200 Highland Avenue	630-737-7610 [Phone]
7th Floor	630-737-4220 [FAX]
Downers Grove, IL 60515	

Filing Company Information

Coventry Health and Life Insurance Co.	CoCode: 81973	State of Domicile: Delaware
6705 Rockledge Drvie	Group Code: 1137	Company Type:
Suite 900	Group Name:	State ID Number:
Bethesda, MD 20817	FEIN Number: 75-1296086	
(800) 843-7421 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	Yes
Fee Explanation:	2 forms X $50 = $100
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Coventry Health and Life Insurance Co.	$100.00	06/25/2010	37536875

SERFF Tracking Number:	*FLHI-126686878*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Co.*	*State Tracking Number:*	*46052*
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Product Name:	*AR PPO Schedule of Benefits and TMJ Lifetime Maximum Rider*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/06/2010	08/06/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	07/14/2010	07/14/2010	Tony Jones	07/27/2010	07/27/2010

SERFF Tracking Number:	*FLHI-126686878*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Co.*	*State Tracking Number:*	*46052*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*AR PPO Schedule of Benefits and TMJ Lifetime Maximum Rider*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 08/06/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FLHI-126686878*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Co.*	*State Tracking Number:*	*46052*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*AR PPO Schedule of Benefits and TMJ Lifetime Maximum Rider*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	No
Supporting Document	Application	Approved-Closed	No
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	No
Supporting Document	Statement of Variability	Approved-Closed	No
Form	Schedule of Benefits	Approved-Closed	No
Form	Temporomandibular Joint Disorder and Craniomandibular Disorder Rider	Approved-Closed	No

SERFF Tracking Number:	*FLHI-126686878*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Co.*	*State Tracking Number:*	*46052*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*AR PPO Schedule of Benefits and TMJ Lifetime Maximum Rider*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/14/2010
Submitted Date	07/14/2010
Respond By Date	

Dear Tony Jones,

This will acknowledge receipt of the captioned filing.

Objection 1

- Schedule of Benefits, TNARMS SOB10_CHL (Form)

Comment:

With respect to benefits payable a PPO and Non-PPO, please provide written certification that benefits payable will comply with our Bulletin 9-85.

Our Bulletin 9-85(2) states in part that...."The difference in benefits levels, i.e., deductibles and co-pay provisions, etc., offered to the insured must not be so great as to practically require that the health care service be rendered by a particular hospital or person.... "The Department will presume that a difference exceeding 25% in benefit levels effectively negates an insured's freedom to utilize non-panel providers....".

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*FLHI-126686878*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Co.*	*State Tracking Number:*	*46052*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*AR PPO Schedule of Benefits and TMJ Lifetime Maximum Rider*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/27/2010
Submitted Date	07/27/2010

Dear Rosalind Minor,

Comments:
Thank you for your letter dated July 14, 2010.

Response 1

Comments: This is to certify that the coinsurance benefit levels between a PPO and a Non-PPO will not be more than a 25% differential.

Related Objection 1

Applies To:

- Schedule of Benefits, TNARMS SOB10_CHL (Form)

Comment:

With respect to benefits payable a PPO and Non-PPO, please provide written certification that benefits payable will comply with our Bulletin 9-85.

Our Bulletin 9-85(2) states in part that...."The difference in benefits levels, i.e., deductibles and co-pay provisions, etc., offered to the insured must not be so great as to practically require that the health care service be rendered by a particular hospital or person.... "The Department will presume that a difference exceeding 25% in benefit levels effectively negates an insured's freedom to utilize non-panel providers....".

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for reviewing our filing.

Respectfully,

SERFF Tracking Number:	*FLHI-126686878*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Co.*	*State Tracking Number:*	*46052*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*AR PPO Schedule of Benefits and TMJ Lifetime Maximum Rider*		
Project Name/Number:	*/*		

Tony Jones

Sincerely,
Nora Ambros, Tony Jones

SERFF Tracking Number:	*FLHI-126686878*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Co.*	*State Tracking Number:*	*46052*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*AR PPO Schedule of Benefits and TMJ Lifetime Maximum Rider*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/06/2010	TNARMSSOB10_CHL	Schedule Pages	Schedule of Benefits	Initial			TNARMS_SOB10_CHL.pdf
Approved-Closed 08/06/2010	AR-MS-TN-TMJ2010-CHL	Certificate Amendment, Insert Page, Endorsement or Rider	Temporomandibular Joint Disorder and Craniomandibular Disorder Rider	Initial		40.900	TMJ CMD Lifetime Max Rider 06082010.pdf

Schedule of Benefits

This Schedule is part of Your Certificate of Coverage (COC) but does not replace it. Many words are defined elsewhere in the COC, and other limitations or exclusions may be listed in other sections of Your COC. Reading this Schedule by itself could give You an inaccurate impression of the terms of Your Coverage. This Schedule must be read with the rest of Your COC. [This is a Qualified High Deductible Health Plan (QHDHP). Please see Section 2.10 For additional information regarding Your benefits.] Coinsurance amounts are a percentage of the Plan's Out-of-Network Rate (ONR). See the last page of this Schedule of Benefits for further explanation. Prior Authorization may be required for some services. Please refer to Your COC for further details or contact Member Services at the phone number listed in the "Schedule of Important Numbers and Addresses" section of Your COC or on the back of Your ID card.

Covered Services	**Member Responsibility In-Network**	**Member Responsibility Out-of-Network**
Annual Deductible Total amount a Member is required to pay each calendar or Contract Year before he or she is eligible for certain Health Services. The Annual Deductible need only be met once per Member per calendar or Contract Year. [Pharmacy Services are included in the Deductible.] **In some cases, In-Network Deductible will not apply.**	Individual [$0-$15,000] Family [$0-$45,000]	Individual [$0-$45,000] Family [$0-$90,000]
Annual Out-of-Pocket Maximum [Copayments,] [Annual Deductible,] [and] [Coinsurance] apply to the Out-of-Pocket Maximum [Pharmacy Services are included in the Annual Out-of-Pocket Maximum.]	Individual [$0-$30,000] Family [$0-$75,000]	Individual [$0-$90,000] Family [$0-$150,000]
[Maximum Annual Benefit] [Combined total of all benefits each calendar year.]	[Individual] [$10,000-Unlimited] [Family [$10,000-Unlimited]]	[Individual] [$10,000-Unlimited] [Family [$10,000-Unlimited]]
[Maximum Lifetime Benefit	[$1,000,000-Unlimited]	[$1,000,000-Unlimited]]

YOU ARE RESPONSIBLE FOR AMOUNTS IN EXCESS OF OUT-OF-NETWORK RATES (ONR) IN ADDITION TO APPLICABLE COMPAYMENT, COINSURANCE AND DEDUCTIBLES.

[Combined total of all benefits.]		
Physician Office - Preventive Care Services include routine health assessment, well-child care, child health supervision services, childhood immunizations, hearing test, annual self-referred gynecological examination and pap smear. [No copayment/coinsurance for well child visits or immunizations under the age of 6. Benefit is not subject to preventive care limitation.] [No copayment/coinsurance for well women exams.] [Maximum benefit is an In-Network and Out-of-Network combined limit.]	For Primary Care Services [$0-$250 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [4-Unlimited visits] For Specialty Care Services [$0-$250 Copay per visit] [or][then[[0-50% Coinsurance per visit] [after Deductible] [Covered in Full]	For Primary Care Services [$0-$250 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [4-Unlimited visits] For Specialty Care Services [$0-$250 Copay per visit] [or][then[[0-50% of ONR Coinsurance per visit] [after Deductible] [Covered in Full]
Physician Office – Medical Services Services include diagnosis, consultation and treatment, diagnostic tests and radiology services, immunizations and injections, surgery, allergy tests and treatment.	For Primary Care Services [$0-$250 Copay per visit] [or][then[[0-50% Coinsurance per visit] [after Deductible] For Specialty Care Services [$0-$250 Copay per visit] [or][then[[0-50% Coinsurance per visit] [after Deductible]	For Primary Care Services [$0-$250 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] For Specialty Care Services [$0-$250 Copay per visit] [or][then[[0-50% of ONR Coinsurance per visit] [after Deductible]
Chiropractic Office Visits Services include treatment that is Medically Necessary, clinically appropriate, and within the chiropractor's scope of practice. [Visit limitation is an In-Network and Out-of-Network combined limit.]	[$0-$250 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible]	[$0-$250 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible]]
Emergency Room Services Coverage is provided for worldwide	[$0-$500 Copay per visit] [or] [then] [0-50%	[$0-$500 Copay per visit] [or] [then] [0-50% of

Emergency Health Services as defined in section [1.39] [1.40] of the COC.	Coinsurance per visit] (waived if the patient is admitted) [after Deductible]	ONR Coinsurance per visit] (waived if the patient is admitted) [after Deductible]
Emergency Ambulance Services Coverage is provided for Emergencies as defined in Sections [1.39][1.41] and [6] of the COC.	[$0-$500 Copay per occurrence] [or] [then] [0-50% Coinsurance per occurrence] [after Deductible]	[$0-$500 Copay per occurrence] [or] [then] [0-50% of ONR Coinsurance per occurrence] [after Deductible]
Urgent Care Services Urgent Care Services at Alternate Facilities both in and out of the Service Area are Covered.	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible]
Maternity Care Office Visits Covered Services include pre-natal and post-natal care, examinations, tests and educational services.	[$0-$250 Copay first visit only] [or] [then] [0-50% Coinsurance first visit only] [after Deductible]	[$0-$250 Copay first visit only] [or] [then] [0-50% of ONR Coinsurance first visit only] [after Deductible]
Maternity Care, Inpatient Hospital Covered Services include all Physician services for mother and newborn(s), delivery, newborn nursery services, and Semi-private room.	[$0-$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per [1-5] day(s)] [up to a maximum of $0-$2000] [per calendar/Contract Year] [after Deductible]	[$0-$1000 Copay] [or][then] [0-50% of ONR Coinsurance] [per admission; per [1-5] day(s)] [up to a maximum of $0-$2000] [per calendar/Contract Year] [after Deductible] [$0-$1000 penalty for failure to precertify. Penalty not to exceed $2500 or 40% of the benefit paid.]
[Alcohol Conditions Office Visits Services include diagnosis, consultation and treatment in a Physician's office.] **[Coverage is limited to $1,000 per calendar year for office visits, outpatient services and inpatient hospitalization combined.]**	[$0-$250 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [[25-Unlimited] Visits] [per calendar/Contract Year]	[$0-$250 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [[25-Unlimited] Visits] [per calendar/Contract Year]
[Alcohol Conditions Outpatient Services: Coverage is provided for treatment of alcoholism in a partial or full day non-	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [0-20% penalty for failure to	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [0-20% penalty for failure to

residential treatment program. Prior Authorization from the Plan's Mental Health and Substance Abuse Designee may be required. The telephone number for the Behavioral Health Line is listed on the back of Your ID card.] **[Coverage is limited to $1,000 per calendar year for office visits, outpatient services and inpatient hospitalization combined.]**	precertify]	precertify]
[Alcohol Conditions Inpatient Hospitalization Services: Coverage is provided for Inpatient Days for treatment of alcoholism and Detoxification. Prior Authorization from the Plan's Mental Health and Substance Abuse Designee may be required. The telephone number for the Behavioral Health Line is listed on the back of Your ID card.] **[Coverage is limited to $1,000 per calendar year for office visits, outpatient services and inpatient hospitalization combined.]**	[$0-$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per [1-5] day(s)] [up to a maximum of $0-$2000] [per calendar/Contract Year] [after Deductible] [$0-$1000 penalty for failure to precertify]	[$0-$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per [1-5] day(s)] [up to a maximum of $0-$2000] [per calendar/Contract Year] [after Deductible] [$0-$1000 penalty for failure to precertify]
Mental Health Conditions and Chemical Dependency Services Office Visits **Services include diagnosis, consultation and treatment in a Physician's office.** Prior Authorization from the Plan's Mental Health and Substance Abuse Designee may be required. The telephone number for the Behavioral Health Line is listed on the back of Your ID card.	[$0-$250 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [25-Unlimited] [Visits] [per calendar/Contract Year]	[$0-$250 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [25-Unlimited] [Visits] [per calendar/Contract Year]
Mental Health Conditions and	[$0-$1000 Copay]	[$0-$1000 Copay]

Chemical Dependency Services Inpatient Hospital **Coverage is provided for Medically Necessary Hospital services, Semi-private room, nursing care, meals.** Prior Authorization from the Plan's Mental Health and Substance Abuse Designee may be required. The telephone number for the Behavioral Health Line is listed on the back of Your ID card.	[or][then] [0-50% Coinsurance] [per admission; per [1-5] day(s)] [up to a maximum of $0-$2000] [per calendar/Contract Year] [after Deductible] [Limited to [20-Unlimited] Days] [per calendar/Contract Year]	[or][then] [0-50% of ONR Coinsurance] [per admission; per [1-5] day(s)] [up to a maximum of $0-$2000] [per calendar/Contract Year] [after Deductible] [$0-$1000 penalty for failure to precertify. Penalty not to exceed $2500 or 40% of the benefit paid.] [Limited to [20-Unlimited] Days] [per calendar/Contract Year]
Mental Health Conditions and Chemical Dependency Outpatient Hospital **Coverage is provided for partial or full day nonresidential treatment programs.** Prior Authorization from the Plan's Mental Health and Substance Abuse Designee may be required. The telephone number for the Behavioral Health Line is listed on the back of Your ID card.	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [[20-unlimited] Visits [per calendar/Contract Year]]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify. Penalty not to exceed $2500 or 40% of the benefit paid] [[20-unlimited] Visits [per calendar/Contract Year]]
Outpatient Services and Diagnostic Procedures and Tests Coverage includes diagnostic procedures and tests, including but not limited to lab and radiology, not performed in the Physician's office. Certain procedures and tests are considered surgery, including but not limited to colonoscopy and endoscopy. Refer to the Outpatient Surgery section.	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify. Penalty not to exceed $2500 or 40% of the benefit paid]
Outpatient Surgery Benefits are provided for Covered Services rendered at an outpatient Hospital and may include an overnight observation stay. Certain procedures	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [per calendar/Contract Year] [after Deductible]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [per calendar/ Contract Year] [after

and tests are considered surgery, including but not limited to colonoscopy and endoscopy.		Deductible] [0-20% penalty for failure to precertify. Penalty not to exceed $2500 or 40% of the benefit paid]
[Outpatient Surgery Freestanding Facility Benefits are provided for Covered Services rendered at a Freestanding surgery center.	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [per calendar /Contract Year] [after Deductible]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [per calendar/ Contract Year] [after Deductible] [0-20% penalty for failure to precertify. Penalty not to exceed $2500 or 40% of the benefit paid]]
TMJ [and CMD] Coverage for Phase I non-surgical treatment. Surgery under Phase II will be Covered as per the Outpatient Surgery or Inpatient Hospital Services (whichever is Medically Necessary) Sections. Refer also to Your COC. [Maximum benefit is an In-Network and Out-of-Network combined limit.] [Lifetime Maximum benefit is listed in the Temporomandibular Joint Disorder and Craniomandibular Disorder Rider]	[$0-$250 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [up to a maximum benefit of [$500-unlimited] per calendar/Contract Year]	[$0-$250 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [up to a maximum benefit of [$500-unlimited] per calendar/Contract Year]
High Technology Diagnostic Services, Tests, and Procedures Including, but not limited to: MRI, MRA, CT Scans, Thallium Scans, Nuclear Stress Tests, PET Scans, Echocardiograms, Ultrasounds	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [per calendar/Contract Year] [after Deductible]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [per calendar/ Contract Year] [after Deductible] [0-20% penalty for failure to precertify. Penalty not to exceed $2500 or 40% of the benefit paid]
[Injectables Includes Injectable medications, allergy and therapeutic injections and	[$0-$500 Copay] [or] [then] [0-50% Coinsurance] per	[$0-$500 Copay] [or][then] [0-50% of ONR Coinsurance] per

chemotherapy. There may be more than one Copayment/Coinsurance charged by the same Provider on the same day.	injection with the exception of immunizations [after Deductible]	injection with the exception of immunizations [after Deductible]]
Inpatient Hospital Services Coverage is provided for Medically Necessary Physician and surgeon services, Semi-private room, operating rooms and related facilities, intensive and coronary care units, laboratory, x-rays, radiology services and procedures, medications and biologicals, anesthesia, special duty nursing as prescribed, short-term rehabilitation services, nursing care, meals and special diets.	[$0-$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per [1-5] day(s)] [per calendar /Contract Year] [after Deductible]	[$0-$1000 Copay] [or][then] [0-50% of ONR Coinsurance] [per admission; per [1-5] day(s)] [per calendar /Contract Year] [after Deductible] [$0-$1000 penalty for failure to precertify. Penalty not to exceed $2500 or 40% of the benefit paid]
Transplant Services Services and supplies for certain transplants are Covered when provided at a Designated Transplant Network Facility and by a Designated Transplant Network Physician. Please see Your COC for further details. **[Donor screening testing is limited to a [$10,000 - unlimited] benefit maximum per Member per Lifetime. This is a combined in-network and out-of-network limit.]**	[$0-$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per [1-5] day(s)] [per calendar /Contract Year] [after Deductible]	Covered only at a Designated Transplant Network Facility by a Designated Transplant Network Physician
Skilled Nursing Facility Coverage is provided when approved by the Plan. Coverage is provided on a Semi-private basis. [Maximum benefit is an In-Network and Out-of-Network combined limit.]	[$0-$1000 Copay] [or][then] [0-50% Coinsurance] [per admission; per [1-5] day(s)] [per calendar/ Contract Year] [Limited to [30-150] days per] [calendar/Contract Year] [after Deductible]	[$0-$1000 Copay] [or][then] [0-50% of ONR Coinsurance] [per admission; per [1-5] day(s)] [per calendar /Contract Year] [Limited to [30-150] days per] [calendar/Contract Year] [after Deductible] [$0-$1000 penalty for failure to precertify. Penalty not to exceed $2500 or 40% of the benefit paid]

YOU ARE RESPONSIBLE FOR AMOUNTS IN EXCESS OF OUT-OF-NETWORK RATES (ONR) IN ADDITION TO APPLICABLE COMPAYMENT, COINSURANCE AND DEDUCTIBLES.

Home Health Care Coverage is provided when services are rendered by licensed Providers and Authorized in advance by the Plan.	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [20-unlimited visits combined services]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify. Penalty not to exceed $2500 or 40% of the benefit paid] [20-unlimited visits combined services]
Hospice Coverage is provided when services are rendered by licensed Providers and Authorized in advance by the Plan.	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [20-unlimited visits combined services]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify. Penalty not to exceed $2500 or 40% of the benefit paid] [20-unlimited visits combined services]
Durable Medical Equipment Coverage is provided when services are rendered by Providers and Authorized in advance by the Plan.	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance of Covered expenses] [after Deductible] [limited to a benefit maximum of $0-$10,000]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance of Covered expenses] [after Deductible] [limited to a benefit maximum of $0-$10,000] [0-20% penalty for failure to precertify. Penalty not to exceed $2500 or 40% of the benefit paid]
Orthotics and Prosthetics Coverage is provided when services are rendered by licensed Providers and Authorized in advance by the Plan. [Maximum benefit is an In-Network and Out-of-Network combined limit.]	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance of Covered expenses] [after Deductible] [limited to a benefit maximum of $0-$10,000]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance of Covered expenses] [after Deductible] [limited to a benefit maximum of $0-$10,000] [0-20% penalty for failure to precertify. Penalty not to exceed $2500 or 40% of the benefit paid]
[Eyeglasses and Contacts Coverage is provided for the first pair of	100% of Covered eyewear up to [$50-$500]	[0-50% of ONR Coinsurance of Covered

eyeglasses or corrective lenses following cataract surgery [Maximum benefit is an In-Network and Out-of-Network combined limit.]		expenses] [after Deductible]]
[Hearing Aids Coverage is provided for hearing aids. [Maximum benefit is an In-Network and Out-of-Network combined limit.]	[$0-$500 Copay per hearing aid] [or] [then] [0-50% Coinsurance per hearing aid] [limited to a benefit maximum of $0-$5000] [after Deductible]	[$0-$500 Copay per hearing aid] [or][then] [0-50% of ONR Coinsurance per hearing aid] [limited to a benefit maximum of $0-$5000] [after Deductible]]
Physical, Occupational, and Speech Therapy Coverage is provided for Medically Necessary outpatient physical, occupational, and speech therapy when rendered by licensed Providers and Authorized in advance by the Plan. [Maximum benefit is an In-Network and Out-of-Network combined limit.]	[$0-$500 Copay per visit] [or] [then] [0-50% Coinsurance per visit] [after Deductible] [Physical therapy: 20-unlimited visits] [Occupational therapy: 20-unlimited visits] [Speech therapy: 20-unlimited visits] [20-unlimited visits combined Physical, Occupational, and Speech therapy]	[$0-$500 Copay per visit] [or] [then] [0-50% of ONR Coinsurance per visit] [after Deductible] [0-20% penalty for failure to precertify. Penalty not to exceed $2500 or 40% of the benefit paid] [Physical therapy: 20-unlimited visits] [Occupational therapy: 20-unlimited visits] [Speech therapy: 20-unlimited visits] [20-unlimited visits combined Physical, Occupational, and Speech therapy]

OUT-OF-NETWORK RATE (ONR)

The "Out-of-Network Rate" or "ONR" is the amount the Plan pays for Covered Services rendered by a Non-Participating Provider for Out-of-Network Benefits. When services are rendered by a Non-Participating Provider, benefits may be paid directly to You upon receipt of Your claim submission.

The ONR is the lesser of the Provider's billed charges or 100% of the current Medicare fee schedule. (Please note that the Medicare fee schedule is updated April 1 of each year.) If there is no corresponding Medicare rate noted for a particular service, the Plan will determine the payment to the Provider.

Please Note: You are responsible for paying any expenses or charges in excess of the ONR.

The examples below illustrate how ONR works:

Assume Your Hospital Coinsurance is 20%, the Hospital bill is $5,000 (actual charges), and the ONR for the Hospital is $3,000. In this example, the Plan would not take into account $2,000 of the $5,000 Hospital bill, because it exceeds the $3,000 ONR. The Plan would pay 80% of the $3,000 ONR, which is $2,400. You would pay 20% of the $3,000 ONR, which is $600, *PLUS* the $2,000 of actual charges that exceed the $3,000 ONR, for a total cost to You of $2,600. Please note that any payments You make in excess of the ONR do not count towards Your Deductible or Out-of-Pocket Maximum.

Assume Your Specialist visit Copayment is $50. The Specialist's bill is $140 (actual charges) and the ONR for the Specialist is $80. In this example, The Plan would not take into account $60 of the Specialist's bill because it exceeds the $80 ONR. The Plan would pay $30 (the ONR minus Your Copayment amount). You would pay the $50 Copayment *PLUS* the $60 of actual charges that exceed the $80 ONR, for a total cost to You of $110. Please note that any payments You make in excess of the ONR do not count towards Your Deductible or Out-of-Pocket Maximum.

By way of contrast, the examples below illustrate how In-Network Covered Services would be paid:

Assume Your In-Network Hospital Coinsurance is 20%, the Hospital bill is $5,000 (actual charges), and the contracted rate for the Hospital is $3,000. In this example, the Plan would not take into account $2,000 of the $5,000 Hospital bill, because it exceeds the $3,000 contracted rate. The Plan would pay 80% of the $3,000 contracted rate, which is $2,400. You would pay 20% of the $3,000 contracted rate, which is $600. The amount in excess of the contracted rate would not be Your responsibility.

Assume Your Specialist visit Copayment is $50. The Specialist's bill is $140 (actual charges) and the contracted rate for the Specialist is $80. In this example, the Plan would not take into account $60 of the Specialist's bill because it exceeds the $80

contracted amount. The Plan would pay $30 (the contracted rate minus Your Copayment amount). You would pay the $50 Copayment. The amount in excess of the contracted rate would not be Your responsibility.

TEMPOROMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR DISORDER RIDER

This Rider is underwritten by Coventry Health and Life Insurance Company ("CHL") issued to the Group on the Effective Date and is made a part of the entire Agreement to which it is attached.

The Schedule of Benefits as modified by this Rider becomes effective on the Effective Date of the Group and expires when the Group's Coverage terminates.

Article 1. Schedule of Benefits

[1. The TMJ benefit description listed in the Schedule of Benefits is changed to read as follows:

TMJ and CMD
Coverage is provided for diagnosis and Medically Necessary surgical treatment of jaw joint disorders. [Annual maximum benefit is an In-Network and Out-of-Network combined limit.]]

[2.] The TMJ and CMD annual maximum benefit amount listed in the Schedule of Benefits is subject to a lifetime maximum benefit of $5,000. [This lifetime maximum benefit is an In-Network and Out-of-Network combined limit.]

Article 2. General Provisions

1. Benefits under this Rider shall terminate according to provisions of the Certificate of Coverage ("COC").

2. Nothing in this Rider shall otherwise extend, vary, alter or waive any of the definitions, provisions, benefits, exclusions, limitations or conditions contained in the COC, other than as stated in this Rider.

SERFF Tracking Number:	*FLHI-126686878*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Co.*	*State Tracking Number:*	*46052*
Company Tracking Number:			
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*AR PPO Schedule of Benefits and TMJ Lifetime Maximum Rider*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	08/06/2010

Comments:

Attachment:

AR Flesch Reading Ease Test.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	08/06/2010

Bypass Reason: We are filing a Schedule of Benefits and a TMJ Rider.

Comments:

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	08/06/2010

Bypass Reason: This is not a PPACA filing.

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved-Closed	08/06/2010

Comments:

In the Schedule of Benefits, we have bracketed text. Text will be either included or excluded based on plan design. Certain benefits have numeric values in a range. Only values within the range will be used. It will be based on plan design. The TMJ and CMD Rider has bracketed text. Text will be either included or excluded based on plan design.

COVENTRY HEALTH AND LIFE INSURANCE COMPANY
2751 Centerville Road, Suite 400
Wilmington, Delaware 19808-1627

FLESCH READING EASE TEST

This is to certify that the form(s) listed below are in compliance with readability requirements pursuant to Arkansas Code Stat. 23-80-206 and have a readability score of forty (40) or higher.

The Flesch Test was applied to each form in its entirety, except that any of the following language may have been redacted: name and address of insurer, name or title of policy, table of contents, captions, subcaptions, policy language which was drafted to conform to any applicable law or regulation, any medical terminology or defined terms in the policy.

FORM NUMBER(S)

AR-MS-TN-TMJ2010-CHL TEMPOROMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR DISORDER RIDER

Secretary

DATE: June 15, 2010